BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **LYNN SWEET, D.O.** Holder of License No. **3246** For the practice of osteopathic medicine in the State of Arizona	**Case No.: DO-10-0001A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came before the Arizona Board of Osteopathic Examiners in Medicine & Surgery ("Board") for review on July 31, 2010. After reviewing relevant information and deliberating, the Board considered proceedings for a summary suspension action against the license of Lynn Sweet, D.O. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License No. 3246, pending formal hearing or other board action. A.R.S. § 32-1855(C).

The Respondent appeared before the Board on July 31, 2010 and was not represented by legal counsel.

JURISDICTIONAL STATEMENT

1. The Board is empowered, pursuant to A.R.S. § 32-1800, et seq., to regulate the licensing and practice of osteopathic medicine in the State of Arizona.

2. Respondent holds license No. 3246 issued by the Board to practice as an osteopathic physician.

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INTERIM FINDINGS OF FACT

1. On December 9, 2009, the Board received a complaint regarding Respondent's prescribing practices. The complaint included allegations of improper prescribing, and prescribing without a complete physical examination.

2. The Board's Investigator John O'Hair Schattenberg conducted a search on the Pharmacy Board's Prescription Monitoring Program database and found that Respondent wrote 10,813 prescriptions for controlled substances between January 1, 2009 and December 27, 2009.

3. On January 4, 2010, the Board received another complaint from the same complainant, alleging that a coworker of his and a patient of Respondent, A.P., died on December 30, 2009. The Maricopa Medical Examiner's Office reported that the cause of death was acute drug toxicity involving the prescription drug oxycodone.

4. On January 4, 2010, the Board also received notification that another patient of Respondent, M.M.R., was found dead by the Maricopa Police Department on November 19, 2008 in her home. The Pinal County Medical Examiner's Office reported that the cause of death was sertraline intoxication.

5. On January 4, 2010, the Board received another complaint regarding another patient of Respondent, T.H., who had been arrested for attempting to obtain prescription drugs by fraud.

6. Dr. Barbara Prah, D.O., a medical consultant for the Board, obtained and reviewed a complete set of medical records from Respondent for patients A.P., M.M.R., T.H., T.P., and J.R.

7. During the investigative hearing on July 31, 2010, Respondent stated that he was currently restricted from prescribing Class 2 narcotics. He stated that he continues to prescribe medications of multiple classes to his patients, and continues prescribing more than one benzodiazepine at a time along with other classes of medication.

8. When responding to the Board's questions, Respondent did not demonstrate an adequate and thorough understanding of the cross-reactivity of the medications he was

prescribed to patients A.P., M.M.R., T.H., T.P and J.R., nor of the appropriate timeliness of intervention and outside evaluation while caring for patients with pain or psychiatric needs.

PATIENT A.P.

9. A.P.'s medical records indicate the following: Respondent prescribed both Xanax and Ambien when A.P. had a history of sleep apnea; A.P. possibly displayed drug seeking behavior in that he stated that his medications were stolen in April of 2009; Respondent saw the patient without documenting a physical exam on February 13, 2008, February 20, 2008, February 27, 2008, June 4, 2008, and July 3, 2008; A.P.'s medical records did not reflect the two seizures he had on June 19, 2008, nor did it contain the medical records from the emergency room nor a work up; Respondent did not refer A.P. to a psychiatrist even though his records indicate that he had a psychiatric history of bipolar disorder and depression, for which he had been placed on a 24 hold in the past, and was on disability for depression and anxiety; Respondent did not respond to a request by CVS pharmacy dated May 12, 2009 relating its concerns that A.P. was overusing alprazolam and carisoprodol; Respondent did not respond to a request by CVS pharmacy also dated May 12, 2009 relating its concerns of possible overuse of A.P.'s prescription for carisoprodol and recommending a reduction of the dosage; there was no diagnosis of migraine or headache in A.P.'s records; A.P. did not sign a pain contract until July 23, 2009 even though he had been a patient of Respondent since November 30, 2007; Respondent physician assistant, Genevieve Smith, saw A.P. on June 26, 2009, did not perform a physical exam and prescribed Ritalin without a diagnosis of attention deficit disorder, which was not diagnosed by Respondent until July 23, 2009, at which point it was diagnosed without a discussion of symptoms, objective findings or a work up; there was no work up regarding A.P.'s back pain, nor a referral to a specialist; there was no consult subsequent to A.P.'s referral to a rheumatologist regarding his diagnosis of fibromyalgia and arthralgias in January of 2008; no confirmatory urine drug tests were performed nor required; and another patient's records were included with A.P.'s records. A.P. died of an oxycodone overdose on December 30, 2009. As of 2009, Respondent was prescribing A.P. all of the following medications: 2 milligrams of

Xanax, at 100 tablets per 30 day refill, Oxycodone, at 240 tablets per 30 day refill, Soma at 120 tablets per 30 day refill, and Celexa, at 30 tablets per 30 day refill.

10. Respondent deviated from the standard of care in failing to conduct a physical examination on February 13, 2008, February 20, 2008, February 27, 2008, June 4, 2008, and July 3, 2008.

11. Respondent deviated from the standard of care in prescribing Xanax and Ambien even though A.P. had a history of sleep apnea, thereby not fully assessing the use of the medications and the side effects.

12. Respondent deviated from the standard of care in that, as a family practitioner, he failed to refer A.P. to a pain specialist or a psychiatrist, despite A.P.'s history of bipolar disorder, depression and pain.

13. Respondent deviated from the standard of care in that A.P.'s records do not indicate that he had attention deficit disorder.

14. Respondent deviated from the standard of care in failing to require A.P. to submit to confirmatory urine drug tests.

PATIENT M.M.R.

15. M.M.R.'s medical records indicate the following: Respondent assumed M.M.R.'s care from nurse practitioner Laurie Frasca, an employee of Respondent, on August 26, 2008; prior to assuming M.M.R.'s care, Ms. Frasca had diagnosed her with insomnia, dysfunctional uterine bleeding, seizure disorder, depression and anxiety and had prescribed her Klonopin, Lexapro, Propranolol, Soma, Carbamzephine, Percocet, Oxycodone, OxyContin, Soma, Cymbalta, Ativan, Tegretol, Seraquel, and Xanax; M.M.R. had a history of alcohol abuse; M.M.R. had also been hospitalized subsequent to an OxyContin, alcohol and morphine overdose on or about April 16, 2007 while under the care of Ms. Frasca; on August 26, 2008, Respondent gave M.M.R. a refill for 15 mg of Oxycodone, at 60 tablets per 30 day refill, and a refill of OxyContin and Xanax without performing a physical examination; no confirmatory urine drug tests were performed nor required; M.M.R.'s care was complicated and Respondent did not

require that M.M.R.'s prescriptions be handled by a pain management specialist or a psychiatrist. M.M.R. died from sertraline intoxication on November 19, 2008.

16. Respondent deviated from the standard of care in failing to conduct a physical examination on August 26, 2008.

17. Respondent deviated from the standard of care in that, as a family practitioner, he failed to refer M.M.R. to a pain specialist or a psychiatrist, despite M.M.R. history of depression, anxiety and pain.

18. Respondent deviated from the standard of care in allowing a nurse practitioner to handle a patient with a complicated medical history.

19. Respondent deviated from the standard of care in that he continued prescribing the same medications, in the same dosages, without any record of a re-evaluation of the patient's condition and without obtaining and reviewing the hospital medical records subsequent to M.M.R.'s overdose on or about April 16, 2007.

PATIENT T.H.

20. T.H.'s medical records indicate the following: Respondent failed to perform an x-ray or work up regarding T.H.'s neck or back pain; Respondent did not perform any laboratories; T.H.'s medical records do not reflect her abuse of marijuana and opiates which is stated on her records from Chandler Regional Medical Center; Respondent did not perform a physical examination on November 6, 2009.

21. Respondent deviated from the standard of care in failing to conduct a physical examination on November 6, 2009.

22. Respondent deviated from the standard of care in diagnosing neck and back pain without a proper examination, including a lack of x-rays or work up.

PATIENT T.P.

23. The medical records of T.P., a patient of Respondent, indicate the following: Respondent did not perform a physical examination on April 13, 2009; Respondent did not require T.P. to follow the pain management contract which directed T.P. to fill her prescriptions

only at CVS Pharmacy; Respondent did not request or require T.P.'s prior medical records; Respondent did not refer T.P. to a pain management specialist despite diagnoses of chronic back pain, hip pain, migraine and leg pain; and no confirmatory urine drug tests were performed nor required.

24. Respondent deviated from the standard of care in failing to conduct a physical examination on April 13, 2009.

25. Respondent deviated from the standard of care in that, as a family practitioner, he failed to refer T.P. to a pain specialist.

26. Respondent deviated from the standard of care in failing to require T.P. to submit to confirmatory urine drug tests.

27. Respondent deviated from the standard of care in failing to require T.P. to comply with the pain contract.

PATIENT J.R.

28. The medical records of J.R., a patient of Respondent, indicate the following: no x-rays or other work up was performed regarding the J.R.'s complaint of back pain; no prior medical records were available for review; no confirmatory urine drug tests were performed nor required; and no laboratory was obtained.

29. Respondent deviated from the standard of care in diagnosing back pain without a proper examination, including a lack of x-rays or work up.

30. Respondent deviated from the standard of care in failing to require J.R. to submit to confirmatory urine drug tests.

PATIENT R.H.

31. The medical records of R.H., a patient of Respondent, indicate the following: no work up was performed regarding the R.H.'s complaint of back pain; no prior medical records were available for review; Respondent did not perform a physical examination for the appointment on August 26, 2009; and no laboratory was obtained.

32. Respondent deviated from the standard of care in diagnosing back pain without a proper examination, including a lack of x-rays, laboratories or work up.

33. Respondent deviated from the standard of care in failing to conduct a physical examination on August 26, 2009.

INTERIM CONCLUSIONS OF LAW

1. Pursuant to A.R.S. § 32-1800, *et seq.*, the Board has subject matter and personal jurisdiction in this matter.

2. The conduct and circumstances described in paragraphs 1 through 33 above, if proven true, constitute unprofessional conduct as defined in the following paragraphs of A.R.S. § 32-1854:

> (6) Engaging in the practice of medicine in a manner that harms or may harm a patient or that the Board determines falls below the community standard.
> (36) Prescribing or dispensing controlled substances or prescription-only medications without establishing and maintaining adequate patient records.
> (38) Any conduct or practice that endangers a patient's or the public's health or may reasonably be expected to do so.
> (44) Conduct that the board determines constitutes gross negligence, repeated negligence or negligence that results in harm or death of a patient.

FINDING OF EMERGENCY

The public health, safety or welfare imperatively required emergency action, pursuant to A.R.S. § 32-1855(C), when the Board summarily suspended Respondent's license to practice osteopathic medicine in the State of Arizona.

ORDER

Pursuant to the authority vested in the Board, and based upon the Interim Findings of Fact and Interim Conclusions of Law, **IT IS HEREBY ORDERED THAT**:

1. Pursuant to A.R.S. §§ 32-1855(C) and 41-1064(C), License No. 3246 held by LYNN SWEET, D.O. to practice osteopathic medicine is summarily suspended in the State of Arizona effective on the date of this order, pending further disciplinary proceedings or until further Order of the Board.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges within thirty (30) days after issuance of the Order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced no later than thirty (30) days from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

4. Service of this Order is effective upon either personal delivery or the date of mailing, by U.S. certified mail, addressed to Respondent's last known address of record with the Board. *See* A.R.S. § 32-1855(F).

ISSUED THIS 10th DAY OF AUGUST, 2010.
STATE OF ARIZONA
BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

By: _____
Elaine LeTarte, Executive Director

Original "Interim Findings of Fact, Conclusions of Law, and Order for Summary Suspension of License" filed this 10th day of August, 2010 with the:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the foregoing "Interim Findings of Fact, Conclusions of Law, and Order for Summary Suspension of License" sent via facsimile and certified, return receipt requested this 10th day of August, 2010 to:

Lynn Sweet, D.O.
Address of Record

Copies of the foregoing ""Interim Findings of Fact, Conclusions of Law, and Order for Summary Suspension of License" via regular mail this 16 day of August, 2010 to:

Camila Alarcon, AAG
Office of the Attorney General CIV/LES
1275 West Washington
Phoenix AZ 85007

Sondra Vanella, ALJ
Office of Administrative Hearings
1400 West Washington, Ste 101
Phoenix AZ 85007